DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**120**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
V46.11 — Ventilator		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
344.00 — Quadriplegia, unspecified	**MM/DD/CCYY**

16. Rendering Provider Number	17. Rendering Provider Taxonomy	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
		99504	**TD**				**12**	**RCS-HH/RN 12°/d, 7d/wk x 53 wks**	**4,452 hrs**	**XX,XXX.XX**
		99504	**TE**				**12**	**RCS-HH/LPN 12°/d, 7d/wk x 53 wks**	**4,452 hrs**	**XX,XXX.XX**
								Shared case with independent nurse. Total hours for all providers will not exceed total hours in plan of care.		

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**X,XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**